the case in a large portion of the state. Currently approximately half of the licensed EMS providers and almost all of the registered first responder organizations in rural/frontier Texas are volunteer and must leave their jobs, or their work in the fields to respond either in their own private vehicle or in areas where they do have an ambulance to transport the patient, the responder must travel to the ambulance station, pick up the ambulance or other emergency response vehicle and respond to the emergency. *Volunteers can be effective, but only with adequate resources.*

In most of the urban areas there are more choices of teaching institutions as well as more EMS providers hosting continuing education courses for different certifications that are beneficial to the EMS personnel no matter what level they are certified at. The financing of rural and frontier EMS organizations is a particular problem due to the relatively low volume of calls in relationship to the essential overhead costs of full-time preparedness, maintenance of the ambulance, fuel, maintenance of the equipment, use of old and/or outdated equipment. Many rural/frontier EMS agencies lack the funding required for their responders to attend CME/CEU courses that are readily available in distant metropolitan areas. In a lot of the urban areas there are taxes that are used for supporting the EMS services; in rural Texas this generally isn't the case.

A major issue faced by the rural/frontier EMS providers is the difficulties faced with billing and collecting for EMS services.

Payment for EMS by Medicare differs widely across not only the state but also across the country. Rural and frontier areas almost always receive a lower reimbursement. There are many reasons for this; one can be attributed to the staffing as well as the billing capability of the volunteer EMS organizations. There is also the fact that a majority of the services that are volunteer do not have the funds to hire personnel to do the billing and do not have the funds to contract with a billing service. With the changes in the MedicareAmbulance Fee with a reduction in the amount of money they can recover for the services they provide.

The viability and the sustainability of rural and frontier EMS is dependant on having the ability to obtain funds to be used for maintaining a minimum level of service that is statewide. Every community in rural and frontier Texas should have a dependable emergency medical provider they can count on. Currently there is a lack of funding initiative that would ensure EMS is recognized as an essential service, which every citizen in the

state should have. Rural areas that provide EMS are vulnerable and may not survive or continue to operate unless it is viewed as an essential service and funding is made a priority.

Even though call volumes are lower in rural and frontier areas, the essential overhead costs of full-time preparedness, maintenance of the ambulance, fuel and the maintenance of the medical equipment remain the same.

As stated previously, payment for EMS by Medicare differs widely across the state, but rural and frontier areas generally receive a lower reimbursement. Reasons for this include staffing and the capability of small and volunteer EMS organizations to provide care and transport for their patients and also bill for their services. This seems to be an issue that really has no bearing on healthcare but has more to do with the cost of providing the services. The bottom line is, when someone calls 9-1-1 and they need an ambulance, they should get one.

The viability and the sustainability of rural and frontier EMS is dependant on having the ability to obtain funds to be used for maintaining a minimum level of service that is statewide. *In the event of a natural or man-made disaster, every community in rural and frontier Texas should have the availability of a timely emergency medical response.* Right now there is a lack of funding and a lack of an initiative to make sure EMS is a living essential service that every citizen in the state should have. *Rural areas that try to provide EMS are vulnerable and will not survive or continue to operate unless EMS is viewed as an essential service, and funding is made a priority.*

How EMS agencies are funded

EMS agencies are funded many different ways throughout the state. Below are some examples of EMS funding sources.

- County EMS services. Funded by the County with tax money from the general budget and the revenue they generate. Staffing may be paid, volunteer, or a combination.
- City service. EMS is funded by the City within their budget from city taxes and the revenue they generate. Staffing may be paid, volunteer, or a combination. These include fire department-based EMS and third city EMS services.
- Private EMS services. There are private EMS services that operate a County or City EMS and may receive a subsidy from the county

or city or both. Staffed by paid personnel.

- Hospital Based EMS services. Funded by hospitals or hospital districts and the revenue they generate, and may receive additional tax funding. Staffing may be paid, volunteer, or a combination.
- Emergency Service District. Districts voted on by the people in the district to have a tax to pay for emergency services (fire and /or EMS). The ESD maximum tax rate is set by the voters. Staffing may be paid, volunteer, or a combination.
- Other innovative funding possibilities.

To calculate the per capita cost of EMS

Calculating the per capita cost of providing EMS may be accomplished by the following method:

Start with a total budget, subtract expected income from billing divide that sum by 8,760 (number of hours in a year) Example:

Budget:	$1,796,289.00
Less expected revenue:	-700,000.00
	1,096,289.00
Total:	1,096,289.00
Divided by number of hours in a year	) 8,760
Cost per hour	$125.15

Now divide the cost per hour by the number of people in a county per 2000 census

Cost per hour:	$125.15
Number of people per census	21,804 people

Cost = less than one cent an hour (0.00573964163)

This works out to approx 14 cents per day (0.13775139912) per person.

The future of EMS... it's up to us

We, as EMS personnel, healthcare workers, elected officials and concerned citizens have an obligation not only to our own community but also to all citizens and visitors across the state of Texas. We must ensure that the Future of EMS is to provide the best care possible to all. Only through collective efforts is it possible for all entities involved in the

evaluation and treatment of the acutely ill or injured patients to decrease death and disability. Participation at local, state, and national levels is crucial if EMS is to fulfill its potential role in caring for the health of America's communities.

There are many professions involved in a comprehensive EMS & Trauma System including EMS providers, medical directors, public health and safety officials, administrators, local, state, and federal government officials, other community leaders and the general public. The future of EMS is a significant looming challenge for Texas. It will require diligent efforts by those who have the resources and capabilities to influence any aspect of the EMS system

To help with the Future of EMS, first a need for change must be recognized, there must be a vision to help indicate where those changes will lead us. The EMS Agenda for the Future (www.nhtsa.dot.gov/people/injury/ems/EdAgenda/final/agenda6-00.htm) identifies the need and offers a vision for the future of EMS that emphasizes its critical role in health care and as the public's emergency medical safety net. The next step toward change is exploration of possible strategies to reach the desired results. The State of Texas' Governor's EMS and Trauma Advisory Council (GETAC) has already started this process with the strategic plan, available for viewing at www.tdh.state.tx.us/hcqs/ems/STRACPlan.pdf.

NHTSA has taken the lead nationally with the development of the National Scope of Practice, (www.emsscopeofpractice.org) with agencies and individuals in the state of Texas by reviewing and offering input. The EMS Education Agenda for the Future may also be viewed at the scope of practice web site.

The path to the future will undoubtedly include barriers. Among them may be a failure to recognize a desirable change, and inadequate exploration of possibilities or a lack of important participation. New and creative partnerships will be required to overcome these barriers. Some partners may seem logical, based upon their current participation in EMS affairs. Others may be found in unlikely places within the health care system, education system, community organizations / agencies and industry. Partnerships must be inclusive. They must seek diversified perspectives and invite enthusiastic participation. Many share the job of making communities healthier. Similarly, the venture to create the future of EMS cannot be done in isolation. It must involve innumerable agencies, organizations, and

individuals that interface with EMS. Local, county and state officials, the medical community and many others will have to be included.

Additional information concerning:

Compilation of Laws that impact EMS and Trauma Systems
Adopted EMS and Trauma Rules
Proposed and Pending EMS/Trauma System Rules
May be viewed at: www.tdh.state.tx.us/hcqs/ems/ruldraft.htm

EMS-related Health and Safety Codes

Creation of Emergency Services Districts

CHAPTER 771.	STATE ADMINISTRATION OF EMERGENCY COMMUNICATIONS
CHAPTER 772.	LOCAL ADMINISTRATION OF EMERGENCY COMMUNICATIONS
CHAPTER 773.	EMERGENCY MEDICAL SERVICES
CHAPTER 774.	LOCAL PROVISION OF EMERGENCY MEDICAL SERVICES
CHAPTER 775.	EMERGENCY SERVICES DISTRICTS
CHAPTER 776.	EMERGENCY SERVICES DISTRICTS IN COUNTIES OF 125,000 OR LESS
CHAPTER 778.	EMERGENCY MANAGEMENT ASSISTANCE COMPACT
CHAPTER 779.	AUTOMATED EXTERNAL DEFIBRILLATORS
CHAPTER 281.	HOSPITAL DISTRICTS IN COUNTIES OF AT LEAST 190,000
CHAPTER 282.	HOSPITAL DISTRICTS IN COUNTIES OF 75,000 OR LESS
CHAPTER 283.	OPTIONAL HOSPITAL DISTRICT LAW OF 1957
CHAPTER 284.	SPECIAL PROVISIONS RELATING TO HOSPITAL DISTRICT BONDS
CHAPTER 285.	SPECIAL PROVISIONS RELATING TO HOSPITAL DISTRICTS
CHAPTER 286.	HOSPITAL DISTRICTS CREATED BY VOTER APPROVAL

LGC 352
LGC 344